Chronic Daily Headache Has Range of Causes

BY DAMIAN McNAMARA
Miami Bureau

SCOTTSDALE, ARIZ. — Consider a chronic daily headache. This progressive disorder is "headache (Curr. Pain Headache Rep. 2005;9:430-5). This progressive disorder is at higher risk for medication-overuse headaches 2 or 3 days a week for months. Improperly selected or improperly dosed medications are possible culprits, said Dr. Saper, founder and director of the Arizona Head Pain & Neurological Institute at the University of Michigan, Ann Arbor.

"My best two pieces of advice are to consider that individual as the first patient you've ever seen with chronic daily headache," he said. "It's not daily chronic headache until you've ruled out everything else." The differential diagnosis includes the other primary headache disorders and organic causes of intractable headache such as sphenoid sinusitis, an Arnold-Chiari malformation, and pseudotumor cerebri.

"The more you treat patients with chronic daily headache, the more you learn you did not get it right the first time," Dr. Saper said.

Patients who take almost any headache medications 2 or 3 days a week are at higher risk for medication-overuse headache (Curr. Pain Headache Rep. 2005;9:430-5). This progressive disorder is characterized by predictable and escalating headache frequency and medication use in patients with pre-existing headache.

"If you start a drug and are not there to deal with its consequences, you put all of us at risk," Dr. Saper said. "You better be willing to monitor them" and change therapy when warranted.

"I was at a symposium of more than 300 physicians, making a diagnosis of a primary disorder difficult. Causes of headache include cerebral venous occlusion. Lyme disease, inflammatory disease, exposure to toxins, AIDS, and opportunistic meningeal infections. Psychiatric, behavioral, and drug misuse barriers are more pervasive than perhaps is appreciated," Dr. Saper said. Remember the basics, such as a thorough physical examination, comprehensive history, and getting collateral information from relatives, he suggested.

"Are we dealing in some cases with challenging headaches or a challenging individual with headaches? It is important to ask when someone is not getting better," Dr. Saper said. Drugs and medication noncompliance are also possible when a patient is not improving, he added.

Interventional procedures are sometimes necessary to treat intractable headaches. A neural blockade such as an epidural or C2-C3 might help, or consider neural stimulation, Dr. Saper said.

"Sometimes, hospitalization is required to reach a correct diagnosis. An outpatient visit is a snapshot, a moment that you spend with that patient," he said. "When trained staff is with a patient 24 hours a day, you begin to learn something about that case you would not learn in an outpatient setting." For example, how does a patient interact with their family? Does the patient sneak down to the hospital cafeteria and eat something they are not supposed to?

Are we dealing in some cases with challenging headaches or a challenging individual with headaches? It is important to ask when someone is not getting better.

Newly Recognized Syndrome Causes Dizziness and Headache

BY ELAINE ZABLOCKI
Contributing Writer

LOS ANGELES — Vertical heterophoria is a newly recognized syndrome responsible for a high proportion of otherwise undiagnosable cases of dizziness and headaches. Dr. Arthur J. Rosner said at the annual meeting of the American Academy of Otolaryngology—Head and Neck Surgery Foundation.

In vertical heterophoria, one eye sees an image higher than the other eye does. This may be caused by the relative position of the eyes or to neurologic or muscular anomalies. The brain is intolerant of the unclear image and responds with compensatory mechanisms. The resulting strain can lead to symptoms that mimic situational unsteadiness when walking, fatigue when reading, and poor depth perception.

"When patients present with dizziness, I check for possible causes such as benign paroxysmal positional vertigo, sinusitis, and tumors," Dr. Rosner said in an interview. "When I rule out the more common diagnoses and I'm left with unexplained dizziness, 90% of the time it turns out to be due to vertical heterophoria."

Dr. Rosner, an otolaryngologist in private practice in Sterling Heights, Mich., uses a Quality of Vision questionnaire to evaluate patients, asking whether they experience double vision, blurred vision, poor depth perception, and other visual problems. Those who score high on the questionnaire are referred to an optometrist.

In his study, 100 patients were sent for optometry evaluation, and 29 of those had vertical heterophoria. They were treated with new glasses using fractional units of vertical and horizontal prism. After treatment, symptoms were evaluated using the Quality of Vision questionnaire, which showed a marked symptom reduction of 50%.

So far, Dr. Rosner has treated more than 500 patients with vertical heterophoria, most of them with Improved or normal vision. The symptoms that were most improved included dizziness on bending down and standing up, blinking to clear vision of distant objects, inner ear disorders, and migraine headaches.

Acronym Helps Identify Red Flags in Acute Severe Headache

BY MICHELE G. SULLIVAN
Mid-Atlantic Bureau

LAS VEGAS — TEASE-First in deciding when to order neuroimaging for headache presenting in the acute setting, Dr. John B. Chawluk said at a symposium sponsored by the American Headache Society.

The acronym will identify most red flags that accompany acute severe headache—signs that there may be a serious underlying problem that needs immediate attention, said Dr. Chawluk of Drexel University, Philadelphia.

Although contrast-enhanced magnetic resonance imaging is most sensitive for some of these underlying conditions—arterial dissection, meningococcal meningitis, and abscess, for example—it may not be immediately available in the acute setting. In that case, it’s best to go with computed tomography, which can usually be obtained very quickly.

"Imaging is mandatory in any of these scenarios," Dr. Chawluk said.

▶ Trauma with headache. Use CT to identify skull fracture, acute hematoma, or subarachnoid hemorrhage.

▶ Escalating severity of headache under observation, including headache that does not respond to acute pharmacotherapy. Use CT to identify subarachnoid hemorrhage or hydrocephalus. If the results are negative, use subsequent contrast-enhanced MRI to identify meningitis, abscess, arteriovenous malformations, or neoplasm.

▶ Altered mental status with headache. Use contrast-enhanced CT to identify arteriovenous malformation, subarachnoid hemorrhage, meningitis, hydrocephalus, neoplasm, pituitary apoplexy, stroke, or subdural hematoma.

▶ Stiff neck. Use CT to identify subarachnoid hemorrhage.

▶ Examination abnormal, including fever or abnormal neurological signs. Use CT to identify subarachnoid hemorrhage or hydrocephalus. Follow-up with contrast-enhanced MRI to identify stroke, tumor, meningococcal meningitis, carotid/vertebral dissection, or venous thrombosis.

▶ First headache, or worst headache ever. Use CT to identify subarachnoid hemorrhage.

Headaches that occur suddenly upon exertion or on waking, he said. A CT will pick up possible causes, including ruptured aneurysm, subarachnoid hemorrhage, or hydrocephalus. "If the CT is negative, move onto a contrast-enhanced MRI to look for abnormalities of the foramen magnum or other pathological processes more sensitively detected by MRI."

Underlying pathology is more commonly seen in the acute setting than in subacute or primary care settings, he said.

In the emergency department, probably about 10% of headache patients have some serious neurologic problems, and about 40% have headache related to systemic disease. The rest are primary headache disorders, Dr. Chawluk added.

DATA WATCH

Estimated Costs of Stroke for 2006 (in billions)

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<thead>
<tr>
<th>Hospital</th>
<th>Direct Costs</th>
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| Nursing home | $1.3 |
| Physicians/other professionals | $3.1 |
| Home health care | $3.1 |

| Mortality* | $6.4 |
| Morbidity | $14.2 |

*Estimated loss in future earnings of persons who will die in 2006, discounted at 3%. Source: American Heart Association